Medicare Part D – Plan Selection Information Medicare #: Name: **Effective Date Hospital A:** Birth Date: **Effective Date Medical B:** ** The information above can be found on your Medicare card, example below Address: MEDICARE HEALTH INSURANCE 1-800-MEDICARE (1-800-633-4227) NAME OF BENEFICIARY JANE DOE Zip Code: MEDICARE CLAIM NUMBER 000-00-0000-A 07-01-1986 Phone: Please write any Insurance you currently have (examples: SeniorCare, Supplemental Insurance, Medicare Advantage or Part D plan, Medicaid (Medical Assistance), Retiree/Employer coverage, etc. The state helps pay Medicare costs (Premiums, deductibles, and/or co-insurance)? □ Yes □ No Pharmacy - 1st Choice: If you are interested in exploring another Pharmacy for a Cost Comparison, please list: **Drug Name** Strength (mg/ml) Dosage(1/day or 30/mo)

Please put spouse's information on the back side of this form if applicable. Feel free to attach a list of your medications provided by your pharmacist.

Medicare Part D - Plan Selection Information

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Address:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	MEDICARE	HEALTH INSURANCE
	1-800-MEDICARE	E (1-800-633-4227)
Zip Code:	NAME OF BENEFICIARY JANE DOE	
Zip code.	MEDICARE CLAIM NUMBER 000-00-000-A	FEMALE
Dhana	IS ENTITLED TO HOSPITAL (PART A	FFECTIVE DATE 07-01-1986
Phone:	MEDICAL (PART E	3) 07-01-1986
	SIGN HERE	
Please write any Insurance you currently have	e (examples: SeniorCare, Su	ipplemental Insurance,
Medicare Advantage or Part D plan, Medicaid (Medical Assistance), Retiree/Employer coverage, etc.		
The state helps pay Medicare costs (Premiums, deductibles, and/or co-insurance)? ☐ Yes ☐ No		
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Pharmacy – 1 st Choice:		
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Drug Name	Strength (mg/ml)	Dosage(1/day or 30/mo)
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